STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
500 Deaderick Street, Suite 850
Nashville, TN 37243
615/741-2364

REGISTRATION OF MEDICAL EQUIPMENT

Public Chapter 780, Acts of 2002, requires that owners of the following medical equipment with the Tennessee Health Services and Development Agency: computerized axial tomographers, lithotripters, magnetic resonance imagers, linear accelerators, and positron emission tomography. The first registration is to occur on or before September 30, 2002. Thereafter, registration should occur within 90 days of acquisition.

Should you wish to provide information not specifically requested or further information with regard to information reported, please attach a separate page to provide such narrative.

1. NAME AND ADDRESS OF FACILITY

(Name)

(Street Address) (County)

(Mailing Address, if different from Street Address)

(City) (State) (Zip) (Telephone Number)

Type of Facility:

☐ ASTC ☐ Hospital ☐ ODC ☐ Physician's Office
☐ Vendor ☐ Other (specify) _____

2. NAME AND ADDRESS OF OWNER OF FACILITY

(Name)

(Mailing Address)

(City) (State) (Zip) (Telephone Number)

3. CONTACT PERSON OR AUTHORIZED AGENT

(Name) (Title)

(Company) (Email Address)

(Mailing Address) (Telephone Number)

(City) (State) (Zip) (Fax Number)

4. EQUIPMENT OWNERSHIP INFORMATION

NOTE: Before you begin – the information below is required for each piece of equipment. If you have two or more of the same type of equipment, please copy this page for each, complete, and attach all pages to the first page of the Registration Form.

A. CT: Does the facility utilize one or more computerized axial tomography (CT) units? ☐ Yes ☐ No

☐ Owned ☐ Leased ☐ Shared (With Whom): _____

☐ Fixed Site ☐ Mobile □ Number of Days (per week) Mobile or Shared: _____

Date Acquired: _____ Initial Cost: _____ Expected Useful Life: _____

Name Brand: _____ Type: ☐ 32 Slice ☐ 64 Slice ☐ Other _____

Serial No.: _____ Assigned No.: _____

Owner (If shared or leased): _____

Location (If other than the facility's address): _____

B. Lithotripters: Does the facility utilize one or more lithotripters? ☐ Yes ☐ No

☐ Owned ☐ Leased ☐ Shared (With Whom): _____

☐ Fixed Site ☐ Mobile □ Number of Days (per week) Mobile or Shared: _____

Date Acquired: _____ Initial Cost: _____ Expected Useful Life: _____

Name Brand: _____ Type/Model: _____

Serial No.: _____ Assigned No.: _____

Owner (If shared or leased): _____

Location (If other than the facility's address): _____

C. MRI: Does the facility utilize one or more magnetic resonance imaging (MRI) units? ☐ Yes ☐ No

☐ Owned ☐ Leased ☐ Shared (With Whom): _____

☐ Fixed Site ☐ Mobile □ Number of Days (per week) Mobile or Shared: _____

Date Acquired: _____ Initial Cost: _____ Expected Useful Life: _____

Name Brand: _____ Tesla Strength: _____

Magnet Type: ☐ Breast ☐ Closed ☐ Extremity ☐ Open ☐ Short-Bore ☐ Other: _____

Serial No.: _____ Assigned No.: _____

Owner (If shared or leased): _____

Location (If other than the facility's address): _____

D. Linear Accelerators: Does the facility utilize one or more linear accelerators? ☐ Yes ☐ No

☐ Owned ☐ Leased ☐ Shared (With Whom): _____

☐ Fixed Site ☐ Mobile □ Number of Days (per week) Mobile or Shared: _____

Date Acquired: _____ Initial Cost: _____ Expected Useful Life: _____

Name Brand: _____ MeV: ☐ 6 ☐ 18 ☐ Other: ____

☐ Single Energy ☐ Photon ☐ Dual Energy ☐ Photon Electron ☐ IMRT

Serial No.: _____ Assigned No.: _____

Owner (If shared or leased): _____

Location (If other than the facility's address): _____

E. PET: Does the facility utilize one or more positron emission tomography (PET) units? ☐ Yes ☐ No

☐ Owned ☐ Leased ☐ Shared (With Whom): _____

☐ Fixed Site ☐ Mobile □ Number of Days (per week) Mobile or Shared: _____

Date Acquired: _____ Initial Cost: _____ Expected Useful Life: _____

Name Brand: _____ Scanner Type: ☐ PET only ☐ PET/CT Combination

Serial No.: _____ Assigned No.: _____

Owner (If shared or leased): _____

Location (If other than the facility's address): _____

I hereby certify that this information is true to the best of my knowledge, information and belief, and that supplemental written notification will be filed with the Tennessee Health Services and Development Agency in the event of any change in the information given in this report.

_____ _____

Signature Date

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